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Department of Health

'Priorities in Medical Research'

GOVERNMENT RESPONSE TO THE THIRD REPORT OF THE HOUSE OF LORDS SELECT COMMITTEE ON SCIENCE AND TECHNOLOGY: 1987-88 SESSION

Presented to Parliament by the Secretaries of State for Health, Education and Science, Scotland, Wales and Northern Ireland by Command of Her Majesty. December 1989

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Priorities in Medical Research

Government response to the Third Report of the House of Lords Select Committee on Science and Technology: 1987-88 Session

PART I

SUMMARY

1.1 This White Paper is the Government's response to the House of Lords Select Committee on Science and Technology's report on 'Priorities in Medical Research'*. It sets out plans to improve the future organisation and management of health research.

1.2 The Select Committee made recommendations for improving the contribution which medical research can make to arrangements for health care and the delivery of health services. Those recommendations were addressed largely to the NHS in England. The Government accepts the principal thrust of the recommendations that a new initiative is required to help the NHS identify and meet its own research needs. But it rejects the Select Committee's proposed solution of a 'National Health Research Authority'.

1.3 However, instead of the Select Committee's proposed solution of a 'National Health Research Authority', the Government proposes to appoint a **Chief of Research and Development** who will advise and act for the Secretary of State for Health across the whole range of his interests in research. The Chief of Research and Development will hold a senior post and assume the present responsibilities of the part-time Chief Scientist for Department of Health research. He or she will also take on new tasks in relation to the NHS. This latter work will include:

— advising the NHS Management Executive on priorities for National Health Service research and managing a programme of NHS research to meet identified needs, particularly research into the efficiency and effectiveness of health services;

— supporting the creation in the NHS of regional and local arrangements for identifying and meeting clinical and service research needs;

— monitoring the service support and facilities provided by the NHS for externally funded research;

— ensuring that research information is widely disseminated and used by managers and practitioners to improve patient care.

1.4 Part II details this proposal and also outlines, in response to the Select Committee's report and subsequent events, arrangements for:—

— ensuring that research remains a strong force in the NHS following the 'Working for Patients' reforms—assisted by the new Chief of Research and Development and his or her staff;

— co-ordination between research funders;

— ensuring that there is a strong industrial research base in the pharmaceutical and medical equipment and supplies industries;

— dealing with other concerns of the Select Committee.

1.5 The Select Committee also made recommendations for strengthening the science base for research. The Government's response on these issues is set out in Part III and covers:

— Government funding for the Science Budget and the Medical Research Council, which has increased in real terms by 29 per cent. and 34 per cent. respectively between 1979-80 and 1989-90;

*: House of Lords Select Committee on Science and Technology, Session 1987-88 3rd Report, 'Priorities in Medical Research'. HL Paper 54.

— maintenance of the basic principles for the organisation of medical research, ie of the dual support system (universities and Research Councils), with most publicly funded medical research being located in (or associated with) medical schools and universities;

— initiatives on clinical research;

— the continued role of charitable funding and its relationship to the Government;

— the pay and career progression of researchers.

1.6 The Government is proud of its record of financial support for medical research. The plans in this White Paper for the Secretary of State for Health to appoint a Chief of Research and Development give further evidence of the Government's commitment to support medical and health research to improve the health and health care of the population.

1.7 The Select Committee's recommendations were largely concerned with England, but some were of wider relevance. Accordingly Part II deals with England only in relation to the Chief of Research and Development. Specific passages dealing with Scotland, Wales and Northern Ireland in relation to recommendations on the identification and meeting of NHS research needs are in paragraphs 2.27—2.32. The rest of this White Paper refers to the UK, except where indicated.

PART II

HELPING RESEARCH SERVE THE NHS

Chief of Research and Development (Recommendations 9.1, 9.2, 9.14 — 9.25, 9.34 — 9.35)

2.1 Research is crucial to the future ability of the NHS to meet the needs of its patients. The Government agrees with the Select Committee that the NHS itself should do more to identify and meet its own research needs. A good deal of research is, and must remain, science led. But the NHS does have needs, particularly for research to improve the effectiveness and efficiency of its operations. The Government therefore proposes to take action in line with the Select Committee's conclusions to help the NHS to articulate and meet its research needs, and to ensure the results of research are disseminated widely and used to develop and strengthen patient care.

2.2 The Secretary of State for Health proposes to appoint a Chief of Research and Development to the Department of Health (DH) including the NHS Management Executive. The Chief of Research and Development (CRD) will:

— be a full-time appointment;

— maintain responsibility for DH research;

— carry out new tasks in relation to NHS research;

— as appropriate, report directly to the Permanent Secretary (DH) or the Chief Executive of the NHS Management Executive (NHSME);

— have authority to act on those officers' behalf. This will include carrying executive responsibility for NHSME research, and attending NHSME meetings;

— chair a reconstituted Departmental Research Committee with a wider focus to embrace research strategies for the NHS as well as DH.

2.3 The CRD will be expected to develop a research programme which meets the priority needs of the Department and the NHS. To this end, the CRD will be asked to:

a. act as the chief adviser to the Secretary of State on his responsibilities for and interests in research;

b. advise DH divisions and NHSME directorates on the formulation of informed customer requirements on policy and management objectives to be met by research and development. These will cover the Department's health policy interests, public health research and personal social services research needs as well as NHS matters of direct concern to the Management Executive. The CRD will direct arrangements for determining priorities amongst bids for central research funds;

c. act for the NHSME in helping the NHS to develop effective and efficient regional and local arrangements for identifying and meeting clinical and health service research needs;

d. advise the NHSME on priorities for research and development in the NHS to be undertaken at national level; and act for the NHSME to oversee the work to carry forward those priorities; including managing the budget for any NHSME research and development expenditure, as determined by the Chief Executive;

e. encourage effective dissemination of the results of research to improve the quality, management and delivery of services;

f. act with the Chief Medical Officer for the Department as a member of the Medical Research Council. The CRD will play a leading role in advising on the future of the Concordat arrangements with the Medical Research Council when they are reviewed in 1991;

g. represent the Department as required in scientific committees and Government advisory bodies;

h. keep under review NHS service arrangements for research which is funded by others (including health research charities, the universities, Research Councils and commercial funders) but which need access to NHS facilities;

i. direct the arrangements for assuring the scientific quality of research directly commissioned by the Department; advise the NHS on the maintenance of scientific standards in its research; and advise on the level of long-term investment in research necessary to ensure Departmental and NHS needs can be met;

j. advise the Secretary of State, as required, on the research being carried out by non-Departmental public bodies for which he is responsible (including, for example, the Public Health Laboratory Service and the Central Blood Products Laboratory).

2.4 In order to carry out these responsibilities, the CRD will need to take an interest in all forms of research, although biomedical research, both basic and applied, will remain principally the concern of the Medical Research Council. He or she will also be concerned with research into any aspect of health, including primary as well as hospital care. Research that might be undertaken by scientific, nursing and other professional staff as well as by medical staff will need to be considered.

2.5 The new post will preserve the individual research interests of DH and the NHS, while giving an opportunity to build good and strong links between them.

2.6 The CRD will identify and review the expenditure and resources contributing to research, and produce a national research strategy to address the clinical and service needs of the Department and the NHS. On this basis more detailed plans for different sectors can be drawn up.

2.7 The post of CRD will be filled by open competition.

Organisation

2.8 The CRD will be supported by a research management division consisting of staff from both DH and the NHS. Additional staff as appropriate will be made available.

2.9 Close contact with the research community will be maintained and the CRD will as necessary convene groups to advise on the development of the programme in particular areas.

2.10 The Government is particularly concerned that NHS research should stay within the main stream of NHS management. For this reason the Government does not favour the setting up of a National Health Research Authority as recommended by the Select Committee. This could cut across the responsibilities of the Management Executive, separating research from service delivery. The appointment of a CRD should ensure that research issues are properly and directly addressed and acted on by the Management Executive and the NHS.

2.11 Overall, the Government believes that the appointment of a CRD, backed by the appropriate staff, will:

a. provide a clear national point of reference for advising the NHS Policy Board and Secretary of State on health research;

b. consolidate research arrangements within the Department of Health;

c. help the NHS and the NHSME to define their research needs, including evaluation of efficiency and effectiveness of forms of treatment and patterns of care and the assessment of health outcomes; and ensure those needs are met;

d. lead to the development of systems for the better dissemination of the results of clinical and health service research so that they can be used to improve services. Ownership of research may be expected to carry with it an enthusiasm and obligation to implement its findings;

e. provide a focus within the Department to ensure that NHS service arrangements for research by external funders, and by NHS itself, continue to be effective and appropriate as the reforms initiated by "Working for Patients" are implemented.

"Working for Patients" (including recommendations 9.29 and 9.30)

2.12 The Government has carried forward its pledge in "Working for Patients" of firm commitment to safeguarding the quality of medical education and research. The Secretary of State for Health in his speech to the medical education and research community on 10 July 1989, set out a range of measures to support the Government's commitment and said "research helps shape the future of the NHS, and its long term benefits must not be neglected for the sake of purely short term considerations". Some of these measures are set out below.

2.13 Purchasers in the NHS — District Health Authorities and General Practitioners — may come under pressure to examine more closely the services needed by patients, and their costs. But the Government believes that good and important research should have nothing to fear from any closer scrutiny that may result. Good research should be able to prove its value and engage support from hospital managers and others. This will include an awareness on their part of the value of research — the benefits of which tend to be on a longer time scale and with relevance to the wider NHS as well as to the local area.

2.14 The following factors should ensure the maintenance of a strong research base and service support for research in the reformed NHS:

a. there is a strong tradition of involvement in research throughout the NHS, backed up by the important role of research in the career progression of medical and scientific staff;

b. the Government will take every opportunity to make plain the *tripartite* nature of the NHS: treating patients today; teaching and training future staff; and undertaking research and development to help improve the future health of the population and patient care. Research is an essential part of the NHS;

c. all hospitals will find that a reputation for high calibre research, especially research into quality and standards of care, will help attract patients. Similarly the scale of provision of time and facilities for research will be a factor that will attract doctors and other senior staff to work in the hospitals concerned;

d. District Health Authorities in England, in concentrating on how best to meet the health needs of their communities, may require local research to identify what those needs are and the effectiveness of services to meet them. There may be room for co-ordination between Districts on research projects, and support from national and regional research projects. The CRD will want to ensure that good quality epidemiological, public health and health services research is carried out and to help Districts to articulate and meet their research needs;

e. the service increment for teaching will be extended to cover the excess service costs not only of teaching but also of research as sponsored by non-commerical funders in hospitals which support undergraduate medical education (meeting 100 per cent. instead of 75 per cent. of excess costs of teaching hospitals). It will be a clearly earmarked payment and distributed below Regions on the basis of both research and teaching activity. It will be reviewed within three years. This should help ensure that costs associated with research do not financially disadvantage the hospital where they are incurred when it contracts to provide services;

f. the Department of Health is seeking to identify, with NHS and research interests, whether there are hospitals which are not eligible to receive the service increment for teaching referred to above, but where research adds significantly to service costs. The Secretary of State for Health has already indicated his willingness to consider a mechanism for helping to meet the extra costs incurred by such hospitals as a result of supporting worthwhile research. The first step is to identify the locations and the costs involved, and this work is in hand;

g. applicants for NHS Trust status will be expected to make clear in their applications the part they propose to play in research, including any proposals to change the existing arrangements;

h. it is proposed that the legislative framework for the future NHS will continue to include a statutory duty to provide facilities for clinical research that are reasonably required by a university which has a medical or dental school. In addition to existing powers to provide and fund health research, the NHS and Community Care Bill proposes to give NHS Trusts the explicit power to undertake and commission research and to make facilities and staff available for research by others. The Secretary of State for Health also proposes to take a reserve power which will enable him to give directions to NHS Trusts relating to research amongst other matters, in the rare event that this will be necessary.

2.15. "Working for Patients" will inevitably cause changes in the ways in which the NHS works. But the Government shares the aims of the research community that research should continue to be a strong force in the NHS. A further major step has been taken to ensure this through the appointment of a Chief of Research and Development. The Government will look to that person to take or advise on any further measures that are needed in England within the framework of 'Working for Patients'.

Co-ordination of Research Activity (Recommendations 9.28, 9.31-9.33)

2.16 Over £1.25 billion per annum is spent by health research funders. The great majority of this money is spent by the pharmaceutical, medical equipment and supplies industries. Of the rest, the main research funders are the universities, the Medical Research Council (MRC) and medical research charities. The UK Health Departments' research programme amounts to just over £25 million. In addition other parts of central government contribute to health research, including the Ministry of Agriculture, Fisheries and Food. In the NHS in England, the 'Locally Organised Research Scheme' (LORS) administered by Regions provides over £11 million for NHS applicants, but research in the NHS is not confined only to this scheme.

2.17 Together with the Select Committee, the Government wishes to retain and foster this diversity which is a source of strength. It rejects pressures for central control and monopoly. Steps will be taken to enhance exchanges of information between the bodies concerned, which with cross-membership of committees will help duplication to be avoided and gaps to be filled. The Government believes that co-ordination on individual issues is best met by mechanisms designed to meet specific needs, rather than an over-arching and perhaps over-bureaucratic committee. Decisions on priorities in research should be left to individual agencies—over most of which the Government rightly has little or no direct control and does not intend to seek it.

2.18 Nevertheless close links are maintained by all UK Health Departments with the Medical Research Council, through the annual stocktaking procedure, membership of its Council and Boards and other means. The Chief Medical Officer will continue to be a member of the Council and the CRD will take the place of the Department of Health's Chief Scientist.

2.19 Links also exist with other research councils, the Universities Funding Council (UFC) and charitable and commercial funders.

2.20 The new CRD will have an important role in representing the interests of DH and the NHS in the wider health research community. He or she will build on existing links in developing his advice to the Permanent Secretary about DH central research, and to the Management Executive about research for the NHS.

Pharmaceutical and Medical Equipment and Supplies Industries (Recommendations 9.40—9.43)

2.21 The Government welcomes the important contribution of the pharmaceutical and medical equipment and supplies industries. This includes provision of health care research for the development and improvement of treatments, building and equipping health care facilities, and benefits to the national economy. The Government agrees with the Select Committee that it is in the national interest to ensure that the United Kingdom maintains a strong industrial research base.

2.22 The Government believes that the United Kingdom continues to provide an attractive environment for international pharmaceutical investment, for a number of reasons. NHS purchasing arrangements include recognition of the costs of research and development which companies incur. Under the Pharmaceutical Price Regulation Scheme, each company is given annually a firm statement of the level of support to be provided in the following year, and provisional indications of support in each of the next two years, thus helping them to plan their R & D budgets.

2.23 The Government notes the Committee's recommendation (9.41) that effective patent life for pharmaceutical products should be protected. However, further progress in protection of pharmaceutical patents would require collective action by a number of European countries. The European Commission has recently begun to address this issue.

2.24 The Select Committee recommended that the pharmaceutical industry should not be charged for the costs of patient care which the NHS would have had to bear in any case when their patients are involved in a clinical trial. The Government accepts this recommendation. But the NHS will continue to make appropriate charges for service support which the NHS would not otherwise engage in. These charges will need to be such that they encourage high quality care without putting one hospital at a disadvantage relative to others.

Other Research Issues (Recommendations 9.26-9.27)

2.25 The Select Committee raised the issue of the publication of research funded by the Department of Health. The Government encourages the publication of research commissioned by DH, and has undertaken that the Secretary of State's consent to publication shall not be unreasonably withheld. In addition the Government has given a commitment to review DH contract conditions early in 1990 if by then there is sufficient evidence that the provisions about publication are damaging research. Directors of Departmental funded research units have accepted the Department's assurances on this matter and no consent to publish has been withheld since the research contract conditions were revised in 1987.

2.26 The Select Committee also raised a query about the use of commercial consultants rather than centres of operational research. Research and information requirements will need to be met in a variety of ways, and the boundaries between research and other methods of enquiry may not always be clear cut. Managers will always be expected to seek the most cost-effective approach.

Scotland

2.27 Existing Scottish legislation does not contain powers to establish a Special Health Authority. However mechanisms have been built up in Scotland which fulfil many of the functional objectives which the Select Committee saw as coming within the domain of the Select Committee's proposed National Health Research Authority. Features of the Scottish system are:

a. **The Chief Scientist Organisation** (CSO), an integral part of the Scottish Home and Health Department, has responsibility for identifying, encouraging, promoting and supporting research and development for the improvement of the NHS in Scotland. The Chief Scientist Office functions as the executive core of CSO. It also has a close working relationship with other parts of the Scottish Home and Health Department, the NHS, health service practitioners, and the research community. The span of CSO activities encompasses the breadth of public health research, the operational research needs of the NHS and locally based clinically orientated research;

b. The standing advisory committees of CSO include a policy committee, the **Chief Scientist Committee,** on which a health service General Manager serves. Annually this Committee sets its priorities for the future research of the CSO and it currently consults General Managers about the provisional list of its priorities. The agreed list of priorities for research is published and is, therefore, apparent to the research community. A specialist **Health Services Research Committee** takes a broad interpretation of this remit to include not only research on organisational and operational matters, but also all public health topics which do not fall readily into the locus of the advisory committees covering clinically orientated research. A Health Board General Manager, the Chief Administrative Medical Officer/ Director of Public Health, and the Chief Administrative Nursing Officer are among the membership of the Health Services Research Committee, as are a general practitioner, community medicine specialist, general physician, general surgeon, sociologist and health economist. The structure of this advisory committee allows proposals before it to be assessed within the context of a good dialogue on NHS requirements and research feasibility of various proposals;

c. Many major research initiatives in Scotland have stemmed from review working groups relating to the Chief Scientist Committee or the Health Services Research Committee. Operational research in the Scottish Health Service is supported by a CSO funded inititative which attracted further funding from a consortium of Health Boards which has established an NHS base for such research. This year a further initiative created a similar jointly funded operational research base in another Health Board;

d. The Chief Scientist is a member of the Health Services Policy Group and the Clinicial Resource and Audit Group. The Chief Scientist and the Director of the Chief Scientist Office have an ongoing dialogue with the senior staff of Health Boards on research priorities. These linkages appear to achieve good input of the needs of the Health Service in formulating priorities for future research. They will be enhanced by changes in the NHS in Scotland following the White Paper "Working for Patients". This provides a new opportunity, not only to increase the relevance and use made of research, but also to form a more coherent bridge with NHS developments to improve health and health services and the manner in which these developments are monitored and assessed. Consideration will be given to improve mechanisms of linking and co-ordinating these activities.

Wales

2.28 Most of the medical research conducted in Wales forms part of an England and Wales programme, and is funded and managed as such. The changes proposed in this White Paper would necessitate significant changes to the research management structure, and the existing joint programme arrangements would not be able to continue in the present format.

2.29 There will be a full review of the arrangements for managing and funding medical research in Wales, which will take account of the need to maintain close links with DH, the Universities, the Medical Research Council, other Research

Councils and medical research charities. A full range of options will be considered, including the establishment of a distinct Welsh research management unit within the NHS in Wales. The Welsh Office will be discussing with DH the implications of the options for the current research commissioning arrangements between the two Departments.

Northern Ireland

2.30 The Select Committe's Report emphasises the need to weld together science led research and service need. The integration of the hospital, community health and primary care services, together with the personal social services, in a unified management structure in Northern Ireland gives the Province a considerable advantage in identifying research opportunities in both the clinical and operational fields which reflect its particular needs.

2.31 The research programme of the Department of Health and Social Services is undertaken principally through three separate organisations whose activities are co-ordinated through common research priorities and an overlap in membership:

a. **Central direction and funding of clinical and operational research** is secured primarily through the Department Research Group (DRG). It considers research proposals in the context of the Department's priorities, which are selected having regard to national priorities specified by the Department of Health;

b. Secondly, the Department also provides direct funding for a **core programme of research** undertaken by the recently established Health and Health Care Research Unit (HHCRU), located in the Faculty of Medicine of the Queen's University of Belfast. The membership of the Unit's Advisory Committee, which advises the Director on the Unit's programme of work, is drawn from the Health and Social Service Boards as well as the Medical Faculty and the Department;

c. the third element of the Department's research programme is **the support of local research** undertaken on its behalf by the **Clinical Research Awards Advisory Committee** (CRAAC). This Committee is made up of senior clinicians with research backgrounds, together with Departmental, University and Board representatives. The Committee considers applications for grants for research projects in the clinical field against priorities determined locally.

2.32 The Government intends to strengthen existing links with the services through regular discussions with Boards on research priorities. These priorities will then provide the content for the commissioning of research by the DRG, HHCRU and CRAAC. The Government believes that this initiative will strengthen existing arrangements for the identification and funding of research projects in both the clinical and operational fields.

PART III

MAINTAINING A STRONG SCIENCE BASE

Government Commitment to Research and its Funding (Recommendations 9.3, 9.4, 9.50, 9.51, 9.52, 9.53)

3.1 It is a source of strength to the nation that the UK has a highly active and innovative research community. The Government's declared policy—in medical as well as other research—is to maintain and enhance the strength and quality of the science base in higher education and the Research Councils, consistent with its responsibility for supporting from public funds basic and strategic research in the national interest. The Government welcomes this opportunity to acknowledge the importance and achievements of those engaged in medical research.

3.2 The Government has provided additional sums for the Science Budget every year since it came to office. Overall the Science Budget has increased from £333 million to £816 million between 1979-80 and 1989-90, a real terms increase (using the GDP deflator) of 22 per cent. Over the same period the allocation to the Medical Research Council (MRC) has risen from £57 million to £176 million, a real terms increase of 29 per cent*. The Secretary of State for Education and Science announced on 15 November 1989 a further increase in the Science Budget for 1990-91 to £897 million; the amount allocated to the MRC will be determined in the light of advice from the Advisory Board for the Research Councils.

3.3 The Government notes the Select Committee's recommendation for a special allocation for the modernisation and re-equipment of UK medical research facilities. But it believes that equipment needs should generally be assessed in relation to the overall requirements of particular scientific programmes and their efficient operation and support. The Government therefore intends to continue its present practice of making more broadly-based allocations from the Science Budget; and of leaving to Research Councils and the universities particular judgements about the most effective balance between spending on equipment and on other items such as staff and consumables.

UK Medical Research Infrastructure (Recommendations 9.5 to 9.12)

3.4 The Government welcomes the Select Committee's endorsement of the basic principles which govern the organisation of medical research in the UK. It endorses the principle of the dual support system which applies generally between the Research Councils and the Universities Funding Council (UFC), and the system of uncosted mutual support which applies for medical research between DES and the Health Deparments. However the Government proposes some changes in the first (the dual support system) to clarify funding responsibilities. The Government also accepts that most publicly supported medical research should continue to be undertaken in, or associated with, medical schools or universities.

3.5 The MRC has well established machinery through its expert Boards and Committees for responding to and anticipating changing needs, and for effecting necessary changes in the balance of the research which it supports. Additionally, reviews by the Council's new Strategy Committee have strengthened these procedures for assessing priorities and allocating resources across each of its Boards.

*excluding the £14 million transfer from DHSS to the MRC in 1981.

MRC and clinical research (Recommendation 9.13)

3.6 The Government and the MRC fully recognise the importance of the contribution of clinicians and will ensure that they continue to be well represented on the Council and its constituent Boards. The MRC has a particular concern to encourage research training for clinicians, supplemented by a range of grant support. It has sponsored a number of new developments in clinical research in recent years, including the establishment of the Institute of Molecular Medicine and a Biochemical and Clinical Magnetic Resonance Unit. The Council is currently planning a further major initiative to strengthen the clinical research it supports and to integrate that better with basic biomedical science and patient care over a range of specialisms.

Role of Charities (Recommendations 9.12 and 9.36-39)

3.7 The Government greatly welcomes the very valuable contribution that the medical research charities make to medical research, and recognises, like the Select Committee, that the donations received by charities give an indication of the public's perception of priorities. But it is also plain that the allocation of research funds by charities can only be one factor in the overall process of setting research priorities. It will, however, be important for that process to involve regular consultations between the new Chief of Research and Development (CRD) and appropriate charities, and between the latter and the MRC.

3.8 The Government understands the concern expressed that any increase in private or charitable funding for research might result in a corresponding reduction in Government support. It has given specific assurances that this is not the position, and is happy to repeat them here. It cannot, however, give equivalent assurances that growth in charitable spending can be matched by growth in public sector research spending.

3.9 The Government has no plans to change the basis on which charities provide support for university research, nor any proposals to reduce the present level of public funding provided indirectly through UFC block grant to underpin university research projects sponsored by charities.

3.10 There is no doubt that university research programmes benefit considerably from charitable funds; and the Government greatly welcomes the substantial increase in charities' support for research over the last decade. However, most such support only covers the direct costs of the research. Indirect costs have to be met from universities' general funds. There are obvious constraints on the extent to which those funds can be redeployed within a university, and thus there cannot be an unlimited commitment to university departments taking on research projects which are sponsored by charities or others at less than their full costs.

Manpower (Recommendations 9.44—9.49)

3.11 The Government agrees that clinical academics' pay should in principle be linked to NHS doctors' pay, which is settled following the recommendations of the Doctors' and Dentists' Review Body (DDRB). The universities will not be given less favourable treatment than the Hospital and Community Health Service in any decisions to provide additional funds to meet additional costs arising from DDRB awards. The operation of this policy resulted in an addition to university funding of £2.8 million in respect of the 1989 clinical academic pay settlement, and this was announced at the same time as the related uplift to NHS cash limits.

3.12 In respect of career prospects and programme grants, the MRC seeks to maintain a balance between long-term career posts—mostly in its own establishments or units but some in universities—and short-term posts supported on grants. At the same time it recognises the need to maintain project grants at a level which will ensure that the best of the new and exciting ideas emerging from the scientific community can be supported.

3.13 The Government accepts that the career progression of those engaged in research, especially clinical research, should be taken into account in decisions on NHS manpower policy. As part of the manpower policy set out in "Achieving a Balance" the number of career registrar and senior registrar posts in each specialty is controlled in line with future consultant opportunities. The Committee which advises on this, the Joint Planning Advisory Committee (JPAC) recognises the importance of research and takes account of the need for research experience in the training grades in each specialty. In addition to this its Academic and Research sub-Committee advises on the number of posts earmarked specifically for research. JPAC will continue its work of reviewing training numbers in each specialty during the ten year implementation period of "Achieving a Balance".

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